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Biological
& Medical
Serials

BULLETIN
AMERICAN COLLEGE
of SURGEONS

VOL. III MARCH, 1918 NO. 3

STANDARD OF EFFICIENCY
for the
FIRST HOSPITAL SURVEY OF THE COLLEGE

Case Records as Tests of Efficiency
Clinical Laboratories
Division of Fees
In the Way of Progress

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25 EAST WASHINGTON STREET, CHICAGO

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STANDARD OF EFFICIENCY

First Hospital Survey of the College

THE Regents of the American College of Surgeons herein state the factors which are the basis of the first hospital survey of the College. These factors are restricted to imperative essentials of good work. They have to do with the keeping of case records and the utilization of these records as tests of efficiency; with clinical laboratory facilities; and with the character of the staff.[1]

By general agreement among doctors and hospital superintendents these factors are fundamental to creditable work in a hospital. They are concerned with the kind of care the patient receives in the hospital. They do not offer a complete test of efficiency, but they draw no false lines. They are easily intelligible to laymen and to doctors. They are applicable to the small hospital and to the large one. They are tests which depend upon constant, earnest effort and of sound training rather than expenditure of money. And, most important, they constitute a simple, workable, and practicable basis of standardization upon which hospitals may meet as a starting-ground for further headway.

An angle of hospital standardization important to remember is this: As a people we are accustomed to hospital service; we look upon that service no longer as a luxury which we may buy, but rather as an inherent right. The humblest patient is entitled to the best of medical service. In the last twenty years especially this idea has taken hold of us. We regard the right to health today much as we regard the right to life.

It follows now that in so far as the right to health is a right of society, all hospitals in a broad sense are public service institutions. On the one hand, hospitals in which sound honest care is given patients may reasonably ask the confidence, good will, and support of their communities; on the other, all hospitals are accountable to the public for their degree of success. By general consent the time has come for an accounting on both sides of the equation. Such an accounting is inevitable. If the initiative is not taken by the medical profession, it will be taken by the lay public; and this entire accounting is what we mean by hospital standardization. It is an analysis of the obligation of the public to support hospitals; and it is a practical accounting to the public of the business and scientific efficiency of hospitals.

Ultimate results of hospital standardization are a matter of evolution, of good will, of honesty and fearlessness in facing facts, of team-work, and of patience. Again, the widely varying conditions under which hospitals operate make hard and fast standards quite impossible. But, remembering these things, there is nothing insurmountable in the task.

To come now to definite criteria upon which hospitals may be justly classified: The policy of the College in its first survey, as already stated, is to define the few factors which are imperative in any hospital for the proper care of patients. Some of these factors must be conceived as flexible in order to meet fairly the various conditions under which hospitals operate. But as definitely as may be the purpose of the College is to define and fully to explain the requirements and then to

[1] In these pages the word staff means the group of physicians and surgeons privileged to practice in the hospital.

classify hospitals according to the degree to which they fulfill them. Details of this minimum standard follow:

I. CASE RECORDS

That the hospital keep in a systematic manner case records of its patients together with a convenient summary of each case; and that it utilize these records in analyses of its medical and surgical efficiency.

What is meant here by case records? These records are the scientific data which pertain to each case treated in the hospital, usually under the following headings, when applicable: Identification of the patient by name or number; name of physician or surgeon responsible for the case; personal history of patient relevant to complaint; diagnosis on which treatment was based; laboratory and physical findings; important points of operation or of treatment; postoperative diagnosis; complications of convalescence; follow-up records; autopsy findings. Case records, when properly kept, provide straightforward and truthful answers to these questions: What was the matter with the patient? What did the doctor do for him? What was the result?

In Bulletin No. 1, revised February, 1918, the College has issued a set of case record forms which may serve as helpful suggestions in the matter of record keeping. Copies of this pamphlet may be had upon request.

The usual purposes assigned for the keeping of case records are: first, their value in medical science; second, their value in the practical care of patients; and, third, their medico-legal value. And in addition to these purposes, the case records serve as an efficiency test in the care of patients which is most important in hospital standardization.

But, in detail, how do case records serve as an efficiency test? Obviously each hospital should undertake to care only for such cases as it is qualified by equipment and personnel to treat, unless the circumstances of its geographic situation or other reasons make it necessary that the hospital accept all cases which seek its aid. The integrity of the profession requires that each hospital should determine whether or not its cases are successfully treated and if not, why not; it requires that the staff by periodic review of its end-results determine the types of cases which, by equipment and training, it is qualified to treat and that, except under unusual circumstances, it limit its service to such cases. Case records provide the information for these reviews. They are not, therefore, merely a clerical procedure; they are the very index of the success of all clinical work in the hospital.

Consistent and fearless review of case records by the hospital staff, as here suggested, is a just and effective means to deal with incompetent medical and surgical work in a hospital. The checking up of end-results and the checking up of diagnoses before and after operation are a practical test of surgery. Facts are not debatable; and facts and then more facts are needed to deal with those difficult problems of unnecessary surgical operations and of operations performed by untrained surgeons. If the facts establish evidence that a physician or surgeon is unsafe in judgment, unworthy in character, untrained, lax, lazy, or careless, in all honor and decency that individual should either overcome his deficiencies or withdraw from practice. Certainly he should neither ask nor receive the privileges of practice in a hospital. In general, it is the business of the staff to take the initiative in this matter. It is the professional duty of the staff to take such initiative. Without the guidance of the staff the trustees are helpless. A wise use of honest case records point the way to great advance in the medical profession.

But in many a hospital the case records, although accurately kept, are not available for review on the part of the staff or of the hospital administration because the significance of the records is lost in details. It is recommended, therefore, that important data in each case be recorded upon a summary card in order that the data may readily be reviewed. To this end the summary card (see opposite page), which for convenience should be about 5 by 8 inches, is suggested:

For the details of this card and for insistence upon its value in hospital efficiency

SUMMARY CARD

Name Address Case No.

Physician's name	Age	Date of adm.	Date of op.	Date of dis.	S M W yrs. yrs.	Re-entry
Address						

Permanent friend's name

Address

Came for relief of

Diagnosis on which treatment was based

Physician or surgeon responsible for treatment

Anæsthetist and form of anæsthesia

Operation or treatment: important points

Complications of convalescence

Pathologic report

Postoperative or final diagnosis

the College is indebted to the Committee[1] of the Clinical Congress of Surgeons appointed by Dr. Edward Martin, Philadelphia. Some explanation of headings of the card is here given.

Name. Address. Case No. Inasmuch as the summary cards are for review by the entire staff and by the hospital administration, it is usually advisable not to enter the name of the patient on the card. The case number is sufficient identification.

Diagnosis on which treatment was based. A physician or surgeon who treats a patient should be willing to state what pathologic condition he believes he is treating. Both the profession and the public realize that in clinical work it is often impossible to be certain that the working diagnosis is correct. With the best of equipment and of medical knowledge diagnoses are frequently incorrect in some details, but when a doctor accepts the responsibility of treatment he is, in fairness to the profession and to his patient, under obligation to state what he believes is the cause of the illness for which the patient seeks relief. If the cause of the illness cannot be determined the physician or surgeon responsible should at least state that fact.

Physician or surgeon responsible for treatment. If one physician or surgeon only is concerned in a case, it is clear that he is responsible. But in modern hospital practice it frequently happens that the responsibility is divided among many individuals. The profession is agreed, however, that in a properly conducted hospital either the chief of the service or one of his subordinates should hold the same position of responsibility toward the patient as does his family physician. When the responsibility is multiple

[1] The personnel of this committee is: Dr. Allen B. Kanavel, Dr. Walter W. Chipman, Dr. John Goodrich Clark, Dr. William J. Mayo, and Dr. Ernest A. Codman.

a physician or surgeon should be assigned to the patient who sees him through the care of other specialists and the name of this physician or surgeon should be entered upon the case record.

Important points of operation or of treatment. Under this heading the physician or surgeon responsible should note only the essential points. He should write down the points which he may wish to know a year later if the patient returns to report his condition. If the operation or treatment is very complicated notation may be "a difficult, complicated operation described in detail in main record."

Complications of convalescence. This heading is most important for efficiency studies. If the word "none" follows the heading, it means that there were literally no complications such as sepsis, bronchitis, cystitis, phlebitis, intercurrent infections, or other conditions resulting directly from the treatment or operation or following it from other causes.

Pathological report. So much of the various pathologic reports as would be important for the person who examines the case a year later to know should be entered under this heading. It is not expected to be a complete statement of the pathology, but merely the main pathologic diagnoses.

Postoperative or final diagnosis. The record here entered is quite essential to an analysis of the efficiency of the work done in the hospital. This final diagnosis should be the one used for filing or cataloguing.

Follow-up Notes. On the reverse side of the card should be entered notes of the case made at subsequent visits of the patient, or from subsequent reports as to the condition of the patient. These notes should be brief, accurate, and fearlessly truthful. In general, the notes under the different headings should be made with the idea that they are available for rapid review. Wherever details are important and yet too extensive to be placed on the card, reference should be made to the main record.

In conclusion the College would emphasize the importance of adequate records. They are in effect a pledge to the public for the integrity of all work done in the hospital. By earnest and constant attention to case records it often happens that an isolated and poorly equipped hospital makes up for its material deficiencies, first, because its staff is inspired always to its highest attainments; second, because by honest selection of its cases it will not undertake the treatment of cases for which it is not equipped. It follows, therefore, that such a hospital may be rated higher than a large hospital with modern equipment and scientific reputation.

2. CLINICAL LABORATORIES

That, as implied in the foregoing requirement concerning case records, the hospital provide either directly or indirectly the laboratory facilities which in the science of medicine are essential in the diagnoses and treatment of patients admitted for care under normal conditions.

While for economic reasons and expediency it is usually advisable that the clinical laboratories be owned and operated by the hospital, neither ownership nor control of the laboratories is essential. In many instances state, county, municipal, or private laboratories supplement to advantage the laboratory facilities of the hospital.

Because of the wide discrepancy in the range of diseases and illness treated by hospitals it is not feasible to stipulate minimum laboratory facilities. Efficient laboratory service is here emphasized rather than details of equipment. The laboratory requirement is, therefore, that the hospital have the constant use of clinical laboratory facilities adequate in the scientific diagnoses and treatment of its patients. The extent of the laboratory facilities with which a hospital should provide itself depends upon the types of cases normally admitted for treatment. In a general hospital the clinical laboratories, under a practical laboratory worker, will provide when adequately equipped, chemical and microscopical examinations, including blood examinations, gastric contents, sputum examinations, urine analyses, fæces examinations, and examinations of cerebro-spinal fluid; bacteriological examinations; patho-

logical and serological examinations; electrocardiographic examinations; and X-ray examinations. The laboratories should include also a postmortem room, instruments for the performance of autopsies, and facilities for the preparation of frozen sections.

3. DIVISION OF FEES

That the hospital trustees or governing authority in co-operation with the staff take action definitely to prohibit from all services of the hospital the practice of division of fees.

The evil of the division of fees is so widely recognized that emphasis of it here is not needed. The practice is prohibited by law in Kansas, Nebraska, Iowa, Minnesota, Wisconsin, Ohio, Alabama, West Virginia, Tennessee, and Colorado. Where it exists under any guise whatever, it is in reality the buying and selling of people who are ill. The consequences of the division of fees are, first, incompetent medical and surgical service; second, unnecessary surgical operations; and, third, the deadening of scientific incentive in the profession and the lowering of the whole profession of medicine into dishonesty. The fact is unchallenged that no intelligent community would tolerate this practice in its midst if the community were aware of the practice and of its significance.

A secret profit made upon the sale of eye glasses or of appliances is considered division of fees.

The College requests each hospital to meet this issue squarely. It asks that by resolution the trustees or governing authority of the hospital in cooperation with the staff of the hospital go on record substantially as follows:

Be it resolved: First, that physicians and surgeons who may have the priveleges of practice in (name of hospital) shall not engage in division of fees under any guise whatever while they avail themselves of these priveleges;

Second, that physicians and surgeons privileged to practice in the aforesaid hospital shall, by the acceptance of these privileges thereby pledge themselves to the following principle:

I hereby agree that as a principle I shall not engage in the division of fees under any guise whatever. By this principle I understand that I am not to collect fees for others referring patients to me, nor to permit others to collect fees for me, nor to make joint fees with physicians or surgeons referring patients to me for operations or consultation, nor knowingly to permit any agent or associate of mine so to do.

Third, that a copy of this resolution shall be conveyed to each physician and surgeon privileged to practice in the aforesaid hospital.

In a large number of hospitals the practice of the division of fees has never existed, and sometimes the staffs of these hospitals are sensitive with regard to passing a resolution as stated above. The Regents of the College believe, however, that these hospitals will, after due consideration, gladly take action as recommended because of the influence which they will have by such action upon hospitals where the practice does exist.

IN THE WAY OF PROGRESS

Neither the hospitals nor the College would ultimately be content with standardization which takes into account only the foregoing minimum standard. Having made a beginning of standardization and agreed upon a common meeting-ground, as stated in the foregoing pages, other important factors of hospital work call for attention. The College respectfully asks that hospital staffs from time to time consider the various problems which, in their judgment, should become part of the standardization program and that they send to the College both suggestions and reports of progress. Some of the phases of hospital work which were considered of prime importance by the General Hospital Committee are here stated,—

THE TRAINING OF INTERNES. The training of internes affects directly a comparatively small percentage of the hospitals. In a larger sense, however, it affects all hospitals and in fact all of the people of the continent, for it has to do, more than is generally realized, with the making of competent physicians and surgeons. Dr. Edward Martin, for instance, estimates that a doctor on graduation from medical school is only twenty per cent efficient as a practitioner of medicine, and

that service as an interne under right conditions may provide nearly eighty per cent of the training of a dcotor. Dr. Allen B. Kanavel writes: "The medical school sends the student from its doors with a diploma asserting that he is qualified to practice medicine, a polite fiction that we have accepted while at the same time belying our acceptance by insisting that the student should serve an interneship."

In Pennsylvania and in Minnesota today the medical graduate is required to serve an interneship of one year before he is licensed to practice. In Pennsylvania the Bureau of Medical Education and Licensure inspects hospitals with special reference to the training of internes; further, it states in what hospitals service as an interne is acceptable in partial fulfillment of the requirements for practice in that state. The leadership in this matter taken by Pennsylvania will undoubtedly be followed by other states.

The staff of each hospital where internes are engaged may well consider the following questions: Do internes receive training in the writing of case records? Do chiefs of departments give instruction to internes at the bedside of patients and throughout the procedure of each case as to the salient points of record-keeping? Are internes under competent guidance trained in the clinical laboratory? Do they follow clinical cases to the laboratory? Do they receive systematic training in the making of postmortem examinations and in the preparation of sections of tissue from postmortems for microscopical examinations? Are they permitted to do independent major surgery or to take full charge of obstetrical cases in the first year of apprenticeship? Do the influences of the hospital make for high ideals of practice? Do they create the right start for a busy, happy, and useful professional career?

The Training of Nurses. The training of nurses came into existence in hundreds of hospitals as a matter of expediency, and it is only in recent years that this subject has been given due consideration. The trained nurse is an indispensable aid in the care of patients. She is also a power in preventive medicine. In fairness now to the nurses themselves, and to the patients whom they are to serve, comes the question as to whether the three years required in the training school are really three years of educational training? Is a sound curriculum provided for the instruction of nurses? Is the teaching under competent supervision? Are pupil nurses sent out into families? If so in what year? Are pupil nurses placed on special cases in the hospital? If so, in what year? Are fees received by the hospital for special duty of pupil nurses? Is the practice medically and educationally justified? The training of the nurse should be given the same thoughtful attention as that given to the interne.

Postmortem Examinations. The keeping of case records implies that postmortem examinations are made whenever consent for such examinations can be obtained. The value of these examinations is here specially emphasized. The postmortem is a merciless criticism of the work of physicians and of surgeons. It is the sort of criticism, however, which physicians and surgeons who are guided by a scientific spirit welcome. There is probably no phase of hospital work which will so definitely put an end to incompetent and unnecessary surgery, and to careless and indifferent diagnoses in medical cases as will a consistent policy of postmortem examinations with staff review of the findings. Further, these examinations, if their results are regularly and fearlessly reviewed by the staff, will serve as a stimulus to scientific work and to valuable investigations. Again, they justify the effort which they cost a thousandfold in their practical value to the immediate relatives of the deceased.

Each hospital staff should ask itself from time to time as to whether or not its percentage of postmortem examinations is as large as could reasonably be expected. Are the complete autopsy reports filed with the respective case records? Does the pathologist meet with the staff to review the clinical histories in relation to autopsy findings? Are the immediate relatives of the deceased informed fully as to the probable value to them of the postmortem examinations?

Obstetrics. More credit than has yet been recognized is due to Dr. J. M. Baldy,

president of the Bureau of Medical Education and Licensure of Pennsylvania, for his insistence that the hospitals of Pennsylvania provide obstetrical departments. Dr. Baldy has also done much to educate the people of Pennsylvania as to the value of hospital obstetrical departments. This whole problem touches in a vital way the conservation of the life of the nation. It means the saving of thousands of babies which unnecessarily die in the first few weeks or months of life. In the next ten years it is reasonably certain that great advancement will be made in obstetrical services. Certainly this whole problem is one which should receive the most earnest consideration of each hospital staff.

If a hospital today does not provide for an obstetrical service, for what reasons is this service neglected? If an obstetrical department is provided, does it include a special delivery room? Does it include a nursery? Is prenatal work conducted in the department; in the out-patient department? Do nurses in the obstetrical department come into contact with patients of other departments?

PEDIATRICS. Closely allied to an obstetrical service is work in pediatrics. The initiative taken recently by various state legislatures providing for the care especially of crippled children is indicative of a general awakening of the people to the value of departments of pediatrics in hospitals. Obviously a hospital should not create such a department unless it is in position to have a trained pediatrician in charge. But if such a department is provided, then some important questions which arise are: Is a receiving and observation ward provided? Is an isolation room provided? Are throat, vaginal smears, and other examinations as to infections made of all children before admission? Do nurses of this department come into contact with patients of other departments?

CROSS INFECTIONS. Does the hospital take all reasonable precautions against cross infection? Are examinations of patients on admission, especially of children, adequate in this respect? Are clean and septic operations conducted in the same operating room? Is the sterilization employed in and about the operating room effective? Is infection possible through the laundry or kitchen? Is constant check kept upon these matters? Are sufficient precautions taken with regard to the passing of nurses from one department into another who may carry infection?

Dietetics, anæsthesia, accurate and intelligible financial accounting, hospital administration, the pharmacy and supervision of prescriptions, and the library and encouragement of research are among other important subjects which merit consideration.

For the Board of Regents of the American College of Surgeons

JOHN G. BOWMAN, *Director.*